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ABSTRACT

Now in its seventh year, the Clinical Parenting class, aimed at parents of children with attention deficit hyperactivity disorder (ADHD), is offered twice a year and attracts an average of 130 attendees at each initial orientation session. The presentation format is quick paced and lively, as presenters are aware of the possibility that many in the audience have "donated" their genetic proclivity toward ADHD. Goals of the parent training series are to: (1) improve parental management skills, and competencies in dealing with child behavioral problems, particularly noncompliance; (2) increase parental knowledge of the causes of childhood misbehavior and the principles and concepts underlying the social learning of such behavior; (3) improve child compliance to commands and rules given by parents; and (4) improve parent and child relationship. More than 800 parents have completed the program. In this program evaluation study, the majority of the 388 parents who completed project questionnaires were 31 to 40 years of age. Sixty-six percent of the program participants rated the program either a four or five based on a five-point scale. it is hoped that other practitioners and administrators will pursue similar programs as a service to their community of parents and children. (JBJ)

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Does Training Parents with Defiant Children Really Work?

Seven Years of Data

Paper Presentation
National Association of School Psychologists
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Does Training Parents with Defiant Children Really Work? Seven Years of Data

BACKGROUND

In the fall of 1989, two staff members of the West End Special Education Local Plan Area, San Bernadino, California, evaluated the potential for adapting the clinical parent training program described in Russell Barkley's *Defiant Children, A Clinician's Manual for Parent Training* (1987 The Guilford Press) for use with many parents in a class format.

By October 1989, a syllabus and necessary materials had been developed, information sent to local schools, and the first class held. A total of twenty parents began the first of twelve weekly two hour sessions, with twelve parents graduating.

Now in its seventh year, the Clinical Parenting Class is offered twice a year and attracts an average of 130 attendees per each initial orientation session. This population includes: parents, teachers, administrators, local clinical therapists, and school psychologists. The average number of parents graduating at the end of the course is 80-90, or about 85% of those who started. It should be noted that as the class has grown in popularity, it has attracted volunteer staff represented by school psychologists, program specialists, clinical social work interns, and clinical marriage and family therapists. It is their crucial support in facilitating small groups that has promoted the program's growth and popularity in the community.

The presentation format is quick paced and lively. The presenters are aware of the strong possibility that many in the audience have "donated" their genetic proclivity toward ADHD to the very offspring they need help in parenting (Murphy & Barkley, 1996). Initial sessions are in a large group and are filled with information regarding why children misbehave. During these first sessions, the attendees learn the latest information about the major factors contributing to child noncompliance. Such factors addressed include: the child's characteristics, parent's characteristics, child rearing practices, family stress factors, and the reciprocal interaction among all these factors. In the weeks that follow, parents continue to observe the presenters role play techniques designed to change their relationship with their children to a more positive and productive one. Observing the leaders model such approaches in a large group, the parents then practice these approaches in small groups as they are coached by the parent trainers. The finale of the evening involves the reassembling of all individuals into the large group where the evening's high points are summarized. Parents are also given assignments to practice the newly learned skills with their children. The last few minutes of the class are reserved for a parent reinforcement experience (raffle).

The specific goals of the parent training series are as follows:

1. Improve parental management skills and competencies in dealing with child behavioral problems, particularly noncompliance.

2. Increase parental knowledge of the causes of childhood misbehavior and the principles and concepts underlying the social learning of such behavior.

3. Improve child compliance to commands and rules given by parents.

4. Improve the parent and child relationship.

The procedures utilized to accomplish the above are taken directly from or have been adapted from Barkley's work, as cited above, as well as from his *Defiant Children Parent-Teacher Assignments*, (1987, The Guilford Press). The steps and the sequence of session presentations are as follows:

* Orientation and introduction to the program objectives
* Understanding why children misbehave Part 1
* Understanding why children misbehave Part 2
* How to pay positive attention to your child, enjoying the payoff
* Increasing your child's compliance to commands and requests
* Decrease your child's disruptiveness; improve independent play
* When praise is not enough; poker chips and points
* Praise Part 2
* Time out! A tool for increasing your child's compliance
* Networking with the school system, parent teacher night
* Managing noncompliance in public places
* Handling future behavior problems; graduation

The authors believe that the information presented here is representative of the most powerful set of parenting tools available for rearing the difficult child. The authors further believe that ongoing use of the materials and procedures described herein have been responsible for enhancing significantly the professional life of the parent trainers, the lives of parents and, most importantly, the lives of their children.

POPULATION CHARACTERISTICS

Enrollment forms, since 1989, show that more than 800 parents began and completed the program. At the end of each program, parents were asked to complete questionnaires about themselves, their children (especially the target child), and grandparents. In this manner, 388 questionnaires were gathered and form the basis for the comments in the following paragraph. It should be noted that in many cases, couples or extended families collaborated in completing one questionnaire. Thus, the 388 forms reflect nearly all of the people who completed the program.

The majority (56%) of the 388 parents who participated in the program and who completed pre/post questionnaires were 31 to 40 years of age. Eighteen of the participants were older than 51 and were the grandparents of the target children. In most cases, these people were either the primary caretakers of the child or shared substantial childrearing responsibilities with the biological parent(s). Almost 70% of the participants were females. Typically, the ratio of female to male was about two to one. It was encouraging to note that the number of males grew from the two who participated in the fall 1990 program to a high of 29 who participated in the fall 1993 class. With regard to ethnic background, slightly more than 85% identified themselves as Caucasian, 11% as Hispanic, with the remainder being Afro-American or Asian. Given the very high rate of single parents in southern California, it was surprising to observe that 84% of the people participating in the program were married. Only 16% were single parents, and of that number, slightly more than half had been married, but divorced. The high number of married participants may be a factor in the program's success. It is presumed that the support individuals can provide each other and the greater opportunities for consistency as they implement the behavior change strategies lead to more successful outcomes. These figures are interesting in light of one study (Barkley, Fischer, Edelbrock, and Smallish, 1990) which found that a significantly greater percentage of biological parents of ADHD children experienced separation or divorce compared with parents of non ADHD children.

Another factor that may be linked to successful outcomes is the educational level of participants. Ninety-nine percent had, at least, a high school diploma. Specifically, 50% were high school graduates, 19% had an associate of arts degree, 20% had a bachelor's degree, 6% had earned a master's degree, and three people with doctorates completed the program. Although not directly comparable, these results were somewhat higher than those found in a recent study (Murphy & Barkley, 1996). In that study, it was found that parents of ADHD children were less educated than the parents of children without ADHD.

Almost 50% of the target children were between the ages of five and eight, with 29% in the nine to twelve-year range. Smaller numbers were represented at the younger and older ranges (e.g., 13% in the two to four year range and 9% in the twelve plus category).

PROGRAM EVALUATION

Participants were asked to list those issues which most concerned them about their children. Those responses which seemed to be logically connected were grouped, named, and rank ordered (most to least). They are as follows:

* Emotional Control Problems
* Low Self-esteem
* School Success
* Future Success in Life
* Peer Interaction Problems
* Defiant Attitudes and Behaviors
* Inattention
* Aggressive Behaviors

With regard to the usefulness of the program in enhancing parenting skills and changing the above behaviors, 66% of participants rated the program at either four or five, based on a five point scale. A "4" rating was described as, "Made a significant difference in my life," and a "5" rating was characterized as "Awesome, among the best things that have happened to me and my family, extremely helpful."

At the conclusion of the series, parents were asked to check which of the eight strategies they continued to use. They are rank ordered below with those most frequently used at the top of the list. Users of Russell Barkley's program will recognize our description of the strategies he developed, which were referred to earlier (Barkley, 1987).

* Paying Attention to Good Behavior
* Giving Effective Commands
* Special Play Time
* Compliance Training
* Token System
* Time Out
* Stopping Interruptions
* Public Places

It is encouraging to know that the more positive interventions were ranked higher than the overtly punitive ones such as Time Out. We believe it is reasonable to conclude that the parents' reliance on positive interventions is at least partially responsible for the continuing positive changes that occurred in their children's behavior.

Parents were asked to further consider how they personally changed in certain dimensions by rating the following statements along a scale of one to five, with five being very significant. The responses to each statement were averaged and rank ordered. (Table 1)

TABLE 1

Rank	Self Rating Dimensions	Mean Ratings
1.	Knowledge regarding why children misbehave	4.03
2.	Enjoyment of my child	3.90
3.	Understanding of the basic principles of behavior management	3.82
4.	Ability to communicate with my child	3.80
5.	My own anger control	3.75
6.	Peace of mind	3.70
7.	Sense of control over my child's behavior	3.62
8.	Sense of confidence as a parent	3.33
9.	Ability to come up with my own strategies	3.20
10.	Communication with school staff	3.09
11.	Need for outside help	2.90
12.	Sense of guilt	1.90

It has previously been reported that parents of children with ADHD have significantly more negative self-attributions compared with parents of non ADHD children. (Fischer, 1990; Mash & Johnston, 1990). The parents who completed this program appear to be gaining in self-esteem, at least as it relates to parenting.

THE HOME SITUATIONS QUESTIONNAIRE

The following summary is based upon parent responses to the Home Situations Questionnaire (HSQ), (Appendix A) which was completed four times throughout the 11 week training period. The first rating was conducted in session two, prior to any treatment, and the last rating was completed during the final session. For the purposes of this paper, only the first and last ratings were used and will be referred to as the "pre" and "post" training scores, respectively. All pre-post comparisons showed statistically significant differences at the .001 confidence level. There were 152 families used in the study of the HSQ. Data were obtained over a seven year period from the spring of 1989 to the fall of 1995.

There are 16 situations on the HSQ. Parents are instructed to decide: 1) if their target child presents a problem with compliance to instructions, commands, or rules in any of the situations, and 2) to indicate how severe that problem is by circling a number from one to nine (with one being mild and nine being severe).

Situations Most Frequently Reported as Problems:

Table 2 reports situations most frequently seen as problems at the beginning and again at the end of the training series. The last two columns display the situations rank-ordered according to the degree of pre-post change.

TABLE 2

N = 151	Total Problem Areas Checked Pre-Training	Total Problem Areas Checked Post-Training	Difference Pre-Post	Pre-Post Difference Rank Ordered	Difference Scores
Playing Alone	60	52	8	Visitors in the home	30
Playing with others	124	102	22	Parent on phone	26
Mealtime	114	99	15	At Bedtime	25
Dressing	115	101	14	Visiting others	24
Washing	94	73	21	Playing with others	22
Parent on phone	132	106	26	With babysitter	21
Watching TV	81	60	21	In the car	21
Visitors in the home	122	92	30	Washing	21
Visiting others	108	84	24	Watching TV	21
Public places	132	121	11	Father is home	18
Father is home	101	83	18	Chores	15
Chores	129	114	15	Mealtime	15
Homework	95	87	8	Dressing	14
At Bedtime	119	94	25	Public places	11
In the car	93	72	21	Playing Alone	8
With babysitter	78	57	21	Homework	8
Means	106.06	87.31	18.75		
Standard Deviations	20.56	19.66	6.22		
Average # of Prolems Checked	11.31	9.44	1.87		

Data from Table 2 demonstrate that the pre and post rank order of situations most frequently reported as problems, in almost all cases, changed very little. However, there was a significant decline in the number of families who continued to report them as problem situations.

Barkley (1990), when comparing 30 hyperactive and 30 non-hyperactive children, reported that situations which tended to be most troublesome included when children were asked to do chores, when parents were on the phone, in public places, and when visitors were in the home. In 1990, Breen and Altepeter collected normative data on the HSQ using 1,060 children. They provided norms for the mean number of problem situations and mean severity scores. These were broken down by gender and three age groups from four to eleven. In addition, they analyzed four other factors: a) Social Interaction, b) Oppositional-Unfocused, c) Oppositional-Focused, and d) Self Engaged. The data in Table 2 support these earlier findings from the perspective of how frequently certain situations were reported as problems. Situations requiring social interaction (e.g., Playing with Others, Visitors in the Home), and those involving unfocused activities (e.g., Public Places, Parent on the Phone), were reported most frequently as problem areas. On the other hand, those situations involving self-engagement - Playing Alone, Watching TV - were reported least frequently as problems.

The pre-training average of reported problem situations was 11.31 (Table 2, Column 1) compared with a post-training average of 9.44. The average number of problem areas that Breen and Altepeter found within the normal population ranged from 2.2 to 4.1. These findings reinforce the authors' view that the population of target children treated in the Clinical Parent Training Program are well beyond the norm with regard to non-compliant behavior.

Situations Ranked by Severity:

Table 3 compares the pre-post mean severity score differences. These scores represent how serious the parents saw their childs' behavior in each of the 16 situations. The table also ranks the situations according to the degree of pre-post difference. Playing Alone, Parent on the Phone and Homework, showed the greatest decrease in severity ratings. It should be noted that those situations which were selected most frequently as presenting a problem, generally tended to rank highest in terms of how severe those problems were rated. The one obvious exception is Homework, which was perceived as the most severe problem situation. Homework continued it's number one ranking following the training, although the level of severity decreased significantly.

TABLE 3

N = 151	Mean Severity Score Pre-Training	Mean Severity Score Post Training	Mean Severity Pre-Post Difference	Situations Ranked by Degree of Pre-Post Difference	Mean Severity Difference Score
Playing alone	4.87	2.29	2.58	Playing alone	2.58
Playing with others	5.01	3.20	1.81	Parent on phone	2.45
Mealtime	5.13	3.16	1.97	Homework	2.38
Dressing	5.11	3.27	1.85	At Bedtime	2.32
Washing	4.45	2.60	1.84	Chores	2.30
Parent on phone	5.79	3.34	2.45	Public places	2.18
Watching TV	5.11	3.13	1.98	Visitors in the home	2.13
Visitors in the home	5.22	3.09	2.13	Watching TV	1.98
Visiting others	4.85	3.12	1.73	Mealtime	1.97
Public places	5.70	3.51	2.18	Dressing	1.85
Father is home	4.96	3.24	1.72	Washing	1.84
Chores	5.93	3.63	2.30	Playing with others	1.81
Homework	6.56	4.18	2.38	Visiting others	1.73
At Bedtime	5.61	3.28	2.32	Father is home	1.72
In the car	4.45	3.04	1.41	With babysitter	1.46
With babysitter	4.67	3.21	1.46	In the car	1.41
Means	5.21	3.21	2.01		
Standard Deviations	0.55	0.40	0.34		

Response to Treatment: Changes in Situational Severity:

Table 3 data demonstrate the effects of the training program on the severity ratings provided by the parents. The last two columns depict the situations ranked according to how much the mean severity scores differed pre-post treatment. Although the situation of Playing Alone was one of the least frequently reported problems and was in the bottom third in terms of severity, it showed the most positive growth during the training. Playing Alone was closely followed by Parent on the Phone and then Homework as situations which showed the most improvement during the training. This may suggest that one of the benefits derived from the retraining of parents' patterns of attending and relating has a strong impact on the child's improved ability to self-engage and play/work independently. The training components of "Paying Attention to Positive Play

Behavior," "Paying Attention to Your Child's Compliance" and "Paying Positive Attention When Your Child is Not Bothering You" are but three of the strategies that specifically focus on this factor.

SUMMARY AND CONCLUSIONS

The current demand upon the time and energy of school psychologists and mental health professionals is considerable. In such challenging times, one must be quite selective while pursuing new avenues for providing quality and cost-effective services to the community. Inherent in such expectations is the continued high demand for effective parent training approaches. It is believed that the information presented in this paper demonstrates the value of such an approach.

With respect to subjectively evaluating the efficacy of this program in assisting parents to reduce noncompliance at home, school and other contexts, the authors have known for some time that the program is a success. It has been consistently observed by the authors that the majority of the parents who attend the initial orientation meeting are, by show of hands, not having a positive relationship with their children. Furthermore, the relationship of these parents with their children's school staff is stressful. The severity of reported behavioral problems of these children parallels closely those described in the normative data presented in the literature (Breen, 1990). In fact, the attendance by many of the parents at this initial information meeting is the result of a strong recommendation by the school staff. However, by the end of the 12-week program, at least 85% of the parents who registered are still with the program and are graduating with smiles and tears and with an abundance of anecdotes chronicling the changes from negative relationships with their children to those of enjoyment and satisfaction.

Objectively, the success of the Clinical Parent Training Program is derived from parent reports on two measures, the Home Situations Questionnaire (HSQ) and a comprehensive exit survey. Significant positive changes were reported on all measures used. The number of problem situations involving the children dramatically declined as did the level of severity of those problem areas still identified. Furthermore, the parents evaluated themselves as having personally changed as a result of this program. Specifically, the parents believed they had increased their knowledge and understanding of child misbehavior, felt they had more effective parenting and child management skills, and believed they had a much improved relationship with their children. The payoff, they believed, was having more compliant children.

The authors continue to speculate regarding the factors which have led to the success of the Clinical Parent Training program. Initially, the authors saw the value of adapting what was an already successful clinical approach to a large group format. Such a revision increased the efficiency with which school psychologists and mental health providers can contribute to the growing need in the community for effective parenting of difficult-to-manage children (a multiplication effect).

Another factor is that the educational community has become more aware of the value of this program through first-hand experience. School administrators and teachers are openly invited to attend some of the educational presentations and are actively encouraged to participate in the Parent/Teacher Night program. As an example of the latter, over the years, several teachers and administrators have been a source of moral support for some of their parents by actually attending the entire program with them.

With respect to the operation of the group format itself, several factors may account for reported successes. Using both large group (educational component) and small group formats (the practice component) promote a greater potential to foster positive changes in parenting behavior. Well established training procedures are used (e.g., Modeling, Molding, and Mimicking). Interest is kept through frequent changes in approach (e.g., role play, lecture format, vignettes laced with humor, and spontaneous interviews of members in the audience). Strategies given to parents to change their children's behavior are imbedded in teaching approaches which change parent behavior ("we practice what we preach"). Parents are expected to do structured record keeping of their attempts to implement learned strategies with their children. Strong reward contingencies are provided to the parents who implement at home what they have learned in the program. One final explanation for the success of the program has been frequently suggested by the parents and by others who have observed the program in action, and that is the camaraderie and sense of humor of the presenters. For the presenters, the involvement in this program is an extremely valuable source of enjoyment and professional satisfaction. The value they derive from their experience is a source of motivation for them to continue their involvement in the program. Furthermore, this enjoyment is contagious, serving to promote the parents continued involvement.

It is believed that this "enjoyment factor" has resulted in the recruitment of other school psychologists/mental health professionals representing several school districts within the Special Education Local Plan Area.

It is hoped that the success of the Clinical Parent Training Program will be a source of inspiration for other school psychologists. mental health providers, and their administrators to pursue this type of program as a service to their community of parents and children.

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